State of California—Health and Human Services Agency

DEPARTMENT OF HEALTH SERVICES
THIRD PARTY LIABILITY/PERSONAL INJURY UNIT, MS 4720
P.O. BOX 997425
SACRAMENTO, CA 95899-7425

THIS IS NOT A BILL, this is a questionnaire being sent to you by Medi-Cal.

SIDE A

Records show that **Medi-Cal has paid** for services for the above illness/injury on or about _____.
If an illness or injury is caused by another person or persons, someone else may be responsible for paying for treatment. As part of our effort to reduce Medi-Cal costs, we request that you answer the following questions.

If you have filed or will be filing a claim with an insurance company, a lawsuit with or without an attorney, or receive money for an injury or illness, state law requires that you or your representative notify the above Medi-Cal office.

PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Do you think someone else was responsible for your illness/injury?	☐ Yes	☐ No
2. Is there any insurance (other than Medi-Cal/Medicare) covering you or anyone else for this illness/injury?	☐ Yes	☐ No
3. Do you plan to pursue a settlement in this matter?	☐ Yes	☐ No
4. Have you hired an attorney?	☐ Yes	☐ No
5. Have you received a settlement (money or judgment) as a result of this illness/injury?	☐ Yes	☐ No

***STOP*. READ THE FOLLOWING INSTRUCTIONS CAREFULLY.**

If you have answered **YES to ANY** of the above questions, **COMPLETE SIDE B** and return this letter using the enclosed postage-paid envelope.

If you have answered **NO to ALL** of the questions, disregard this letter—**DO NOT RETURN**.

Information about any claim or legal action you may take is requested by authority of the Welfare and Institutions Code, Sections 10020, 10022, 10024, 14000, 14023, 14024, 14124.70 through 14124.79, and Title 22, California Administrative Code, Section 50771. We use your Social Security number provided under the Title 22 California Administrative Code Section 50187 and other information for contacting insurance companies, providers of health care, county agencies, or your attorney. The information obtained is also used to seek collections from insurance companies or other sources.

ATTENTION—PLEASE READ THE LETTER ON THE OTHER SIDE BEFORE COMPLETING THE FOLLOWING.

PART 1. INJURED PERSON

1. Name of injured person
2. Date of birth (Month/Day/Year) ____/____/____
3. Social Security number ____—____—____

Address (number, street) City ZIP code

4. Medi-Cal number
5. Date of injury (Month/Day/Year) ____/____/____

Telephone number
Work ( ) Home ( )

6. What type of accident did you have?
☐ Auto ☐ Slip and Fall ☐ Malpractice ☐ Other

7. Briefly describe your injury

8. If you were in an auto accident, do you have auto insurance coverage? ☐ Yes ☐ No If yes, complete items 9 through 14.

9. Name of your insurance company and agent
10. Name of policyholder
11. Policy or claim number

Address City ZIP code

12. Have you received a settlement? ☐ Yes ☐ No
13. If yes, when? (Month/Day/Year) ____/____/____

Telephone number
( )

14. If yes, how much money did you receive?
$

Were any other Medi-Cal recipients injured in this accident? ☐ Yes ☐ No If yes, complete the following.

15. Name
16. Date of birth (Month/Day/Year) ____/____/____
17. Social Security number ____—____—____

Address (number, street) City ZIP code

18. Telephone number
( )
19. Medi-Cal number

PART 2. DID ANOTHER PERSON CAUSE THIS INJURY? ☐ Yes ☐ No If yes, complete the following.

20. Name of person who caused this injury
21. Do they have insurance coverage?
☐ Yes ☐ No If yes, complete items 22 through 27.

22. Name of insurance company and agent
23. Policy or claim number
24. Name of policyholder

Address (number, street) City ZIP code

25. Have you received a settlement? ☐ Yes ☐ No
26. If yes, when? (Month/Day/Year) ____/____/____

Telephone number
( )

27. If yes, how much money did you receive?
$

PART 3. DO YOU HAVE AN ATTORNEY FOR THIS INJURY? ☐ Yes ☐ No If yes, complete the following.

28. Name of attorney
29. Have you received a settlement? ☐ Yes ☐ No
30. If yes, when? (Month/Day/Year) ____/____/____

Address (number, street) City ZIP code

31. If yes, how much money did you receive?
$

Telephone number
( )

32. Civil Complaint number County filed

PART 4. WAS YOUR INJURY CAUSED BY YOUR JOB? ☐ Yes ☐ No If yes, complete the following.

33. Name of Employer
34. Name of employer's insurance company

Address City ZIP code

Address City ZIP code

Telephone number
( )

Telephone number
( )

35. Is a Worker's Compensation action going on now?
☐ Yes ☐ No
36. If yes, write WCAB case number here
37. Insurance claim number

STATE LAW REQUIRES THAT THE MEDI-CAL PROGRAM BE REPAID IF ANY JUDGMENT, AWARD, OR SETTLEMENT IS RECEIVED FOR THIS INJURY.

38. Comments

39. Name of injured minor or person unable to complete this form.
40. Your relationship to injured person.

41. Signature of person completing this form.
X
42. Your phone number
( )
Date

RETURN THIS LETTER USING THE ENCLOSED POSTAGE PAID ENVELOPE